No. 89-1048

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

FMC CORPORATION,
Petitioner,

v.

CYNTHIA ANN HOLLIDAY,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF THE TRAVELERS INSURANCE COMPANY AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

Whether the Employee Retirement Income Security Act of 1974, as amended, pre-empts a State law insofar as it prohibits self-funded employee benefit plans from requiring plan beneficiaries to reimburse the plans for medical expenses paid on their behalf and later recovered by them as damages in tort cases involving motor vehicles?

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INTEREST OF *AMICUS CURIAE*

The Travelers Insurance Company ("Travelers") and its affiliates provide services to uninsured employee welfare benefit plans covered by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"). Travelers receives and processes benefit claims; prepares administrative forms; prepares and distributes summary plan descriptions, plan documents, and other forms and disclosures required by ERISA; calculates funding requirements; makes cost estimates; assists in plan design; and prepares materials required by governmental agencies.

A significant number of the uninsured plans for which Travelers provides such services cover participants in more than one State. By permitting each State to con-

trol the terms and conditions of multi-state plans, the decision below will require similarly-situated participants to be treated differently according to their State of residence. This significantly disrupts the plans' abilities to estimate and project benefit costs, adds additional claims processing costs and benefit costs to the plans' funding burdens, increases total health care expenses, and conflicts with the Congressional objective of ensuring uniformity of regulation of uninsured ERISA plans.

For these reasons, the decision below adversely affects the plans of Travelers' customers and, thus, the business and operations of Travelers.*

SUMMARY OF ARGUMENT

The court of appeals rendered the pre-emption provisions of ERISA needlessly complex. It read into those provisions qualifications and limitations that cannot be supported by statutory language or congressional intent. It adopted, without explanation, an erroneous interpretation of ERISA's saving clause that makes pre-emption turn on the form of the State law, rather than its actual effect. The court compounded this error by misinterpreting the deemer clause, which the court found necessary to consider only because of its misreading of the saving clause.

A.

The court's critical mistake was its failure to recognize that under ERISA a State law dealing with several subjects is pre-empted *only* insofar as it "relates to" employee benefit plans. ERISA's "saving" clause rescues a State law that would otherwise be pre-empted if the law regulates insurance. But the portion of a law directed at self-funded plans cannot thereby be saved. Such plans are not insurance companies and States can-

* Letters from the parties consenting to the filing of this Brief have been filed with the Clerk of this Court. See Sup. Ct. R. 37.3.

not treat them as such. To the extent that a State law regulates self-funded plans, ERISA therefore pre-empts it because, to that extent, the State is not regulating insurance.

Here, Pennsylvania's anti-subrogation law applied to both employee benefit plans and insurance companies. After concluding that the Pennsylvania statute would therefore be pre-empted as a law relating to ERISA plans, the court turned to the saving clause. In this regard, ERISA required the court to consider the Pennsylvania law only insofar as it applied to plans, which is all that would otherwise have been pre-empted.

Instead of doing so, the court treated the saving clause as embodying an all or nothing proposition—either the entire Pennsylvania anti-subrogation statute was pre-empted or the entire statute was saved. Without explanation, the court then interpreted the saving clause to mean that if the *principal* effect of a State law is on the insurance industry, the entire law—including the portion regulating ERISA plans—escapes pre-emption as a law regulating insurance. Pennsylvania's law, the court concluded, was therefore saved.

The court's interpretation of the saving clause is completely untenable. It makes pre-emption turn on how a State chooses to frame its legislation. If, for example, Pennsylvania enacted a separate statute barring only employee benefit plans from subrogating, ERISA would require the law to be struck down. Such a statute would clearly "relate to" plans covered by ERISA and could not be saved as a regulation of insurance since employee benefit plans are not insurance companies, even under Pennsylvania's definition.

That Pennsylvania combined, in one section, its subrogation ban against ERISA plans with a ban against insurance companies should lead to no different result. Both types of statutes equally frustrate Congress's goals. ERISA does not dictate what benefits plans must pro-

vide or what conditions plans may attach to those benefits. Congress decided that to do so as a matter of federal law would threaten its objective of encouraging employers to institute such plans voluntarily and to expand the coverage of existing plans. State laws, such as Pennsylvania's, pose precisely the same threat. By precluding plans from recovering medical expenses paid to employees, Pennsylvania has necessarily increased the costs of providing such coverage. Moreover, if Pennsylvania is permitted to regulate plans in this manner, multi-state plans will be subjected to a welter of different and potentially conflicting State laws, a burden ERISA's pre-emption provisions were designed to remove.

Under ERISA, it was therefore irrelevant that Pennsylvania imposed a mandatory and costly regulation on employee benefit plans in the same statute applying that regulation to the insurance industry. The court's conclusion that the principal effect of the Pennsylvania law was on insurance companies misses the crucial point—namely, that ERISA pre-empts a State law insofar as it governs employee benefit plans regardless whether that is the State law's primary objective, principal purpose or secondary effect.

The court's application of a test to determine whether the practice of subrogation constitutes the "business of insurance" was therefore wide of the mark. Pennsylvania's anti-subrogation law as applied to insurance companies was not threatened with pre-emption and did not have to be saved from that fate. The only aspect of the law challenged here dealt with employee benefit plans, not the business of insurance. The purpose of the saving clause—to preserve State authority over the insurance industry—was not implicated.

In short, the court of appeals failed to appreciate that, because ERISA pre-empts a State law only insofar as it relates to employee benefit plans, that is the only

aspect of the State law to be considered under the saving clause. Since the bar against plans like FMC's from seeking reimbursement for medical expenses was not saved as an insurance regulation, the Pennsylvania law as applied to employee benefit plans was pre-empted.

B.

It was therefore unnecessary for the court of appeals to proceed to the third step of ERISA pre-emption analysis under the deemer clause, which provides that States may not deem employee benefit plans to be insurance companies in their laws regulating the insurance industry. The court's interpretation of the deemer clause was, in any event, wrong.

The court read the clause to mean that States may not regulate "core ERISA concerns" under the guise of insurance regulation. As the court saw it, core ERISA concerns were limited to reporting, disclosure and nonforfeitability. The language of the deemer clause obviously lends no support whatever to this interpretation. Moreover, the court's ruling resurrects limitations on pre-emption Congress specifically rejected. Earlier versions of ERISA limited pre-emption to the areas described by the court, but Congress decided that this was too restrictive and therefore, in the final version of the bill, significantly broadened its provisions.

The purpose of the deemer clause is to ensure that States cannot immunize their laws from pre-emption by defining employee benefit plans to be insurance companies. Giving effect to the plain meaning of the clause is sufficient to accomplish its purpose. The court's reluctance to do so was caused by its misinterpretation of the saving clause, which allowed State laws to escape pre-emption in their entirety despite the fact that they regulated plans. However, when the saving clause is properly interpreted along the lines discussed above, there is no reason for supposing that the deemer clause means anything other than what it actually says.

ARGUMENT

I. ERISA SHIELDS THE CONTENTS OF EMPLOYEE BENEFIT PLANS FROM STATE CONTROL

Employee welfare benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 88 Stat. 829, as amended, 29 U.S.C. §§ 1001 *et seq.* (1985 & 1989 Supp.), provide benefits to employees and their beneficiaries "for contingencies such as illness, accident, disability, death, or unemployment." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91 n.5 (1983). Plans covered by ERISA may pay benefits directly from employer and/or employee contributions ("self-funding") or they may purchase insurance policies for their beneficiaries. FMC Corporation's ("FMC") plan is self-funded.

The FMC plan, *inter alia*, pays the medical expenses of company employees and their family members injured in motor vehicle accidents. *FMC Corp. v. Holliday*, 885 F.2d 79, 80 (3d Cir. 1989). As a condition to receiving these medical benefits, the beneficiary must agree to reimburse the plan if he or she later recovers medical expenses as damages in an action against the tortfeasor. *Id.* at 81. Through such provisions, plans are relieved of the financial burden caused by the fault of another and are able to control costs for the benefit of all participants. Without a reimbursement condition, employees who receive such recoveries in tort actions would be unjustly enriched at the plans' expense.[1]

State laws prohibiting reimbursement or subrogation in motor vehicle accident cases necessarily raise the cost

[1] In Pennsylvania, as in other States, plaintiffs in tort cases may recover damages for medical expenses incurred as a result of their injuries regardless whether they paid the expenses themselves. *Denardo v. Carneval*, 444 A.2d 135, 140 (Pa. Super. Ct. 1982) (Pennsylvania law clear that tort victim entitled to damages regardless of reimbursement from other sources); *Gallo v. Yamaha Motor Co.*, 526 A.2d 359, 367 n.13 (Pa. Super. Ct. 1987) (medical insurance does not negate tort recovery for medical expenses).

of coverage for these plans.[2] Barring self-funded plans like FMC's from being reimbursed for medical expenses requires the plans either to make up the losses through increased employer or employee contributions, or to drop or reduce their coverage of certain medical expenses. *See Liberty Mut. Ins. Group v. Iron Workers Health Fund*, 879 F.2d 1384, 1385 (6th Cir. 1989) (employee benefit plan excluded coverage of medical expenses resulting from automobile accidents).

To allow States to dictate plan terms in this manner not only would be contrary to the interests of the covered employees, but also would be at odds with one of the fundamental goals of ERISA. Employee benefit plans are not mandatory. Employers institute such plans on a voluntary basis. Through ERISA, Congress sought to encourage the formation of new plans and the expansion in coverage of existing plans. As Congress knew, these plans are costly undertakings for employers.[3] Con-

[2] In Pennsylvania, it was thought that subrogation in motor vehicle accident cases resulted simply in taking money "from one insurance company's pocket and putting it into another insurance company's pocket." *Pennsylvania Legis. J.*, 167th Sess. at 2171 (Dec. 13, 1983) (remarks of Rep. Manderino). Apparently, the hope was that by barring subrogation, litigation between insurance companies would be reduced, and that more insurance premium dollars would therefore be devoted to benefits rather than to processing claims.

Whatever might be said for this rationale, it does not apply to self-funded employee benefit plans such as FMC's. Such plans are not profit-making enterprises. Under ERISA Section 404(a)(1)(A), all plan assets, which include amounts collected through subrogation and reimbursement, must be used for the "exclusive purpose of providing benefits to participants and their beneficiaries . . . ."

[3] Much of the bill for health care in the United States is now paid by employer-sponsored plans. A recent survey indicates that "[b]usiness's share of the nation's doctor bill has grown to a staggering 45% of operating profits." Farnham, *No More Health Care on the House*, Fortune, Feb. 27, 1989, at 71. The cost of maintaining such plans is escalating even more rapidly than health

gress recognized that if federal law required particular benefits, this could defeat ERISA's goal.[4] The greater the cost, the more likely employers would respond by narrowing existing plans or refusing to establish new ones. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11-13 (1987). In ERISA, Congress therefore decided not to "mandate that employers provide any particular benefits" (*Shaw*, 463 U.S. at 91).

Congress did not intend the States to fill this void. Because State laws regulating the terms of voluntary plans could have the same counterproductive effect Congress

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care costs in general. In 1989, the cost of employer-provided health care rose by 20 percent, to an average of $2,600 per employee. *See Health Care Keeps Taking Bigger Bites of the Economy*, BusinessWeek, Feb. 19, 1990, at 22. Employers facing these enormous expenses are naturally intent on keeping them under control. *See* Loomis, *The Killer Cost Stalking Business*, Fortune, Feb. 17, 1989, at 58. *See generally Employer-Sponsored Retiree Health Insurance: Hearing Before the Subcomm. on Oversight of the House Comm. on Ways and Means*, 100th Cong., 2d Sess. (1988).

[4] *See, e.g.*, S. Rep. No. 383, 93d Cong., 1st Sess. 18 (1973):

> Generally, it would appear that the wider or more comprehensive the coverage, vesting, and funding, the more desirable it is from the standpoint of national policy. However, since these plans are voluntary on the part of the employer and both the institution of new pension plans and increases in benefits depend upon employer willingness to participate or expand a plan, it is necessary to take into account additional costs from the standpoint of the employer. If employers respond to more comprehensive coverage, vesting and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans.

The same rationale underlies ERISA's regulation of employee welfare benefit plans. *Viggiano v. Shenango China Div. of Anchor Hocking Corp.*, 750 F.2d 276, 279 (3d Cir. 1984); *Musto v. American Gen. Corp.*, 861 F.2d 897, 912 (6th Cir. 1988), *cert. denied*, 109 S. Ct. 1745 (1989).

was determined to avoid, ERISA established "plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981); *see also id.* at 511. Furthermore, if each State could decide for itself what an employee benefit plan must contain, multi-state plans would become subject to a welter of different and potentially conflicting requirements. *See Fort Halifax*, 482 U.S. at 11-13. The increased costs of instituting a plan in an anti-subrogation State, for example, could discourage multi-state employers from offering all of their employees the same plan regardless of the State of their employment. In that manner, the law of one particular State could unduly influence or control the terms of a plan that was regional in scope.[5]

II. THE COURT OF APPEALS MISINTERPRETED ERISA'S SAVING CLAUSE

The Pennsylvania Motor Vehicle Financial Responsibility Law, enacted in 1984, 75 Pa. Cons. Stat. Ann. §§ 1701 *et seq.* (Purdon 1989 Supp.), requires insurers issuing liability insurance policies[6] covering motor vehicles to include, among other things, "a medical benefit in the amount of $10,000 . . . ." § 1711. Insurers issuing

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[5] *See, e.g.*, S. Rep. No. 127, 93d Cong., 1st Sess. 29 (1973) ("it is evident that the operations of employee benefit plans are increasingly interstate. The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws."); H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973) (same); 120 Cong. Rec. 29,933 (remarks of Sen. Williams) (1974) ("It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans.").

[6] Liability insurance indemnifies the insured for tort or statutory liability to third persons based on covered "occurrences" or accidents.

first party benefit policies[7] are also required to include, in each such policy, coverage of liability in the minimum amounts required by Section 1711. § 1715(c).

Automobile insurance policies issued under the Pennsylvania law are "primary" with respect to other payment sources, except worker's compensation. The injured person recovers from the automobile insurance company and, if the loss exceeds the policy's first party benefit limits, only then from "[a]ny program, group contract, or other arrangement" providing medical and other benefits. § 1719(a). Under Section 1720, however, there is "no right of subrogation or reimbursement from a claimant's tort recovery" in a motor vehicle accident case with respect to benefits payable from sources listed in Section 1719, the "coordination of benefits" provision.[8] As interpreted by the court of appeals, the phrase "other arrangement" in Section 1719(a), and consequently the anti-subrogation provision in Section 1720, applies to all

[7] First party benefits are paid to the insured without regard to whether the insured was at fault.

[8] At the time the case was decided Section 1720 provided that:

> In actions arising out of the maintenance or use of a motor vehicle, *there shall be no right of subrogration or reimbursement from a claimant's tort recovery* with respect to workers' compensation benefits, benefits available under Section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or *benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits)*. 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984 Supp.) [emphasis added].

This Section was amended on February 7, 1990, effective July 1, 1990, which changed the last clause to "or benefits paid or payable by a program, group contract or other agreement whether primary or excess under Section 1719 (relating to coordination of benefits)." 75 Pa. Cons. Stat. Ann. § 1720, as amended by Motor Vehicle Insurance, Pleadings, Operators of Commercial Vehicles, Act of Feb. 7, 1990, Pub. L. No. 11, § 1720, 1990 Pa. Legis. Serv. No. 1 (Purdon).

medical benefit plans regulated by ERISA. *FMC Corp.*, 885 F.2d at 82.

To decide whether the Pennsylvania law was pre-empted, Section 514(a) of ERISA required the court of appeals to determine first whether the State law "related to" employee benefit plans.[9] If it did, ERISA pre-empted the "law" unless it came within Section 514(b)(2)(A), which provides:

> Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

If the State law were saved from pre-emption by Section 514(b)(2)(A), the court would then proceed to the third step of determining whether the law nevertheless fell under the "deemer" clause of Section 514(b)(2)(B).[10]

As we next discuss, after correctly holding that the Pennsylvania statute "related to" employee benefit plans, the court of appeals incorrectly determined that the law *as applied to such plans* came within the saving clause exception to pre-emption in Section 514(b)(2)(A). As a result of this error, the court found it necessary to proceed to the third step of pre-emption analysis under

[9] Section 514(a) provides:

> Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b). This section shall take effect on January 1, 1975.

[10] The deemer clause provides:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

ERISA. Here too the court erred by resurrecting under the deemer clause a pre-emption test Congress had specifically rejected when it revised these provisions in conference.

A. As Applied to Plans Covered by ERISA, Pennsylvania's Anti-Subrogation Law Was Not Rescued from Pre-Emption by the Saving Clause

Pennsylvania's anti-subrogation law, as interpreted by the court of appeals, plainly "relate[d] to an employee benefit plan" within the meaning of Section 514(a) of ERISA. *FMC Corp.*, 885 F.2d at 84. *See Shaw*, 463 U.S. at 96-97. The Pennsylvania statute directly regulated such plans, dictating the terms by which plans could provide medical benefits for participants involved in motor vehicle accidents. As a result, the reimbursement condition in the FMC plan was rendered unenforceable under State law.[11]

Neither Pennsylvania's Motor Vehicle Financial Responsibility Law nor the anti-subrogation provision in it were, however, threatened with pre-emption in their entirety. ERISA instead contemplates "pre-emption as applied." Section 514(a) thus invalidates State laws "only insofar as they relate to" employee benefit plans. *Shaw*,

[11] Unlike FMC's plan, some plans purchase insurance policies for their beneficiaries. It might be argued that Pennsylvania's anti-subrogation law also "related to" those plans. The point is, however, academic in light of *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), which holds that insurance policies purchased by plans are not immune from State laws generally regulating insurance companies.

On the other hand, *Metropolitan Life* makes clear that a State's regulation of self-funded plans raises a different issue regarding pre-emption. The Court noted that Massachusetts, which required certain insurance policies to contain mental health benefits, did not require self-funded plans to do so, "effectively conceding that [such] application . . . would be pre-empted by ERISA." 471 U.S. at 735-36 n.14.

463 U.S. at 85 n.17.[12] The point is critical when the saving clause of Section 514(b)(2)(A) is considered.

The saving clause represents a narrow exception to Section 514(a). It rescues some laws that would otherwise fall under Section 514(a) insofar as they apply to ERISA plans. To be saved, the law must constitute a regulation of insurance. Since Section 514(a) would pre-empt only the portion of a State law relating to plans, that portion of the law must regulate insurance in order to survive pre-emption.[13] Therefore, with respect to the Pennsylvania statute in this case, the question under the saving clause was whether the anti-subrogation provision *as applied to* employee benefit plans escaped pre-emption as a law regulating insurance. That, however, is a question the court of appeals never addressed.

Instead, the court embarked upon an entirely different inquiry. Without explanation, the court interpreted the saving clause to shield State laws in their entirety, regardless of their effect on employee benefit plans, so long as the "principal and substantial effect" of the law is "on the insurance industry." *FMC Corp.*, 885 F.2d at 86.[14] The court did not make clear whether, in finding

[12] In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), for example, Mississippi's common law of bad faith applied to contracts in general, including insurance contracts. The Court held that ERISA pre-empted Mississippi's law to the extent it governed employee benefit plans. The rest of Mississippi's law remained standing because it did not relate to ERISA plans.

[13] State laws relate to plans but nevertheless regulate insurance when they control the terms of insurance policies purchased by plans to cover participating employees. See note 11, *supra*.

[14] The court merely cited two other court of appeals decisions adopting, without explanation, a similar construction of Section 514(b)(2)(A). *See Northern Group Servs. v. Auto Owners Ins. Co.*, 833 F.2d 85, 89 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988) (Michigan's coordination of benefits law fell within the saving clause because it "is aimed principally at different types of *insurance* coverage.") (emphasis in original); *United Food &*

this "principal and substantial effect" test satisfied, it evaluated the Pennsylvania Motor Vehicle Financial Responsibility Law as a whole or only the section dealing with subrogation.[15] Neither did the court explain what factors a judge should consider in measuring the "effect" of a particular law. For their part, the parties simply agreed that the Pennsylvania law regulated insurance and devoted their arguments to the effect of Section 514 (b)(2)(B), the deemer clause. 885 F.2d at 85.

The court's interpretation of the saving clause is not correct. Pre-emption cannot depend upon whether the "principal and substantial effect" of a State's law is on insurance. To say that a State law primarily affects one thing is to concede that it also affects something else, here employee benefit plans. But State laws controlling plans do not escape pre-emption for that reason. It is of no importance that a State's regulation of ERISA plans is contained in a broad legislative package aimed at the

Commercial Workers v. Pacyga, 801 F.2d 1157, 1161 (9th Cir. 1986) (Arizona's anti-subrogation law was within the saving clause although it applied to both "insurance companies and private parties"). *Pacyga* held, however, that the Arizona law ran afoul of the deemer clause and was therefore pre-empted. 801 F.2d at 1161-62.

[15] The court seemed to be assessing Pennsylvania's Motor Vehicle Financial Responsibility Law in its entirety:

> We agree that Pennsylvania's Financial Responsibility Law plainly "regulates insurance" within the meaning of the savings clause. 885 F.2d at 85-86.
>
> Insofar as the Financial Responsibility Law expressly regulates insurance contracts, it necessarily falls within the ambit of the savings provision. *Id.* at 86.
>
> . . . the Financial Responsibility Law "regulates insurance . . . ." *Id.*

Only once in its analysis of the saving clause did the court specifically mention the anti-subrogation provision. *Id.* ("The statute's coordination of benefits and anti-subrogation provisions directly control the terms of insurance contracts.").

insurance industry.[16] Otherwise, the saving clause becomes dependent on how the State has framed its legislation rather than on the ERISA policies it was intended to implement.

To illustrate, suppose a State's anti-subrogation measure were directed at employee benefit plans *alone*. No one could have the slightest doubt that such a law would be pre-empted.[17] Even if the State added a second section dealing only with subrogation by insurance companies, the first section would still control employee benefit plans, and could not be saved from pre-emption as a law regulating insurance.

Yet there is only one distinction between the State law just hypothesized and Pennsylvania's anti-subrogation provision—namely, the Pennsylvania prohibition against insurance companies and employee benefit plans is contained in one statutory section rather than two. As far as ERISA is concerned, however, that is a distinction without a difference.[18] The effect on a plan's terms, its

[16] *See Alessi*, 451 U.S. at 525 ("ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the pre-emption provision.").

[17] A State law along the following lines, for example, would clearly be invalid: "an employee benefit plan shall have no right to be reimbursed by an employee to whom the plan has provided medical benefits when such employee has recovered medical expenses in a suit against the tortfeasor." *Cf. Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825, 829 30 (1988). Such a law would plainly "relate to any employee benefit plan" within the meaning of Section 514(a) and could not be saved from pre-emption by Section 514(b)(2)(A) because it would not be a law "which regulates insurance." *See* pp. 17-18, *infra*.

[18] Invalidating Pennsylvania's statute as applied to employee benefit plans, as we suggest, may raise the question whether this portion of the State law is severable from the rest of the statute. This is solely a matter of State law. *See, e.g., Davis v. Michigan Dep't of Treasury*, 109 S. Ct. 1500, 1509 (1989); *Exxon Corp. v. Hunt*, 475 U.S. 355, 376 (1986). *See also Attorney General v. Travelers Ins. Co.*, 433 N.E.2d 1223, 1225 (Mass. 1982), the case

finances and its administration is identical. ERISA's goal of encouraging voluntary employer action is equally threatened in both situations. The danger of conflicting State regulation of multi-state plans is precisely the same. Regardless whether the State's legislation mainly deals with insurance or some other subject, when a State applies its law to plans covered by ERISA it is regulating those plans, not insurance companies.[19]

B. Under the Saving Clause It Is Irrelevant That the Effect of Pennsylvania's Law Was Mainly on Insurance Companies

The language and purpose of the saving clause do not support the lower court's construction. The clause simply provides that nothing in Section 514(a) shall relieve any person from the duty of complying with a State law regulating insurance. The purpose of the clause is to preserve the States' long-standing authority, reflected in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, over the business of insurance. *Metropolitan Life*, 471 U.S. at 742. Congress anticipated that many plans, rather than being self-funded like FMC's, would purchase insurance. H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 292, 296 (1974). If the insurance policies purchased by those plans were not subject to State law, there could be a gap in regulation because ERISA does not itself control the business of insurance.[20]

But none of this leads to the conclusion that State laws dictating the contents of employee benefit plans are saved from pre-emption whenever they are contained in a statutory provision primarily aimed at the insurance industry. Plans covered by ERISA are not insurance companies nor are they engaged in the business of insurance,[21] and State laws regulating insurance cannot be applied to them. In-

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underlying *Metropolitan Life*, in which the State court held that the provisions relating to the insurance industry, which were not pre-empted, were severable from the provisions pertaining directly to employee benefit plans, which all parties assumed were pre-empted.

Pennsylvania law provides that "[i]f any provision of any statute *or the application thereof* to any person or circumstance is held invalid, the remainder of the statute . . . shall not be affected thereby" unless the court finds that the remaining provisions are so "inseparably connected" with the void provision that the General Assembly would not have enacted the "remaining valid provisions," or unless the court finds that the "remaining valid provisions, standing alone, are incomplete and are incapable of being executed in accordance with the legislative intent." 1 Pa. Cons. Stat. Ann. § 1925 (Purdon 1989 Supp.) (emphasis added).

[19] *See Alessi*, 451 U.S. at 524, treating as immaterial the fact that a State statute's primary purpose was not to govern the terms of ERISA plans, when in fact the statute had that effect.

Section 514(c) defines "State law" to mean "all laws, decisions, rules, regulations, or other State action having the effect of law," and defines "State" to mean a State, its political subdivisions and agencies which "purport[] to regulate, *directly or indirectly*, the terms and conditions of" employee benefit plans (emphasis added). As *Alessi* holds, even if the State regulation is not directly aimed at employee benefit plans, it is pre-empted to the extent that such plans are swept within the scope of the State law.

[20] There is thus a distinction "between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not," but that is "a distinction created by Congress." *Metropolitan Life*, 471 U.S. at 747. See note 11, *supra*.

[21] Throughout ERISA, Congress clearly distinguished between plans, on the one hand, and insurance companies or insurance carriers, on the other. *See, e.g.*, Sections 3(17) (definition of "separate account"); 103 (annual report requirements); 301 (defining insurance contract plan as, *inter alia*, plan with benefits guaranteed by an insurance carrier); 302(b)(5)(B)(iii)(II) (as amended) (interest rate for determining plan's current liability shall be consistent with assumptions that would be used by insurance companies); 401(b)(2)(A) (defining insurer in context of plan to which guaranteed benefit policy is issued by an insurer); 403(b) (establishment of trust requirement not applicable to assets of plan consisting of insurance policies issued by insurance company or to assets of such insurance company or plan assets held by such company); 408 (exemptions from prohibited transactions); 514(b)(2) (insurance savings clause and deemer clause).

deed, the Pennsylvania Attorney General so instructed the State's insurance commissioner shortly after ERISA was enacted.[22] Yet the court of appeals, by allowing the "principal effect" of State law to control, has obliterated the clear-cut distinction between plans and insurance, a distinction ERISA's pre-emption provisions were carefully designed to preserve.

In deciding that the Pennsylvania law mainly affected insurance, the court of appeals used a three-part test to determine whether the practice of subrogation constituted the "business of insurance." *FMC Corp.*, 885 F.2d at

[22] *See* Office of the Attorney General, *Minimum Premium Agreements and Administrative Service Plans*, Opinion No. 75-22 (June 30, 1975), 5 *Pennsylvania Bulletin* 1804, 1805 (July 5, 1975). After observing that the relationship between a self-funded plan and its participants is not one of seller and purchaser, with profits accruing to the seller, the Pennsylvania Attorney General concluded that self-funded plans "which assume part or all of the risk of indemnity to employes do not constitute the transaction of insurance business under Pennsylvania insurance laws and are not subject to regulation by the Insurance Department." The Attorney General further noted that ERISA:

> specifically regulates employer-sponsored programs and exempts them from regulation under state insurance laws . . . .
>
> Accordingly, where an employer assumes full responsibility for paying out benefits, the plan would be governed completely by [ERISA]. Where a minimum premium agreement is in operation, the employer's liability under its own plan would be regulated by [ERISA], but the premium agreement and any other contractual relationships between an employe benefit plan and an insurer would remain subject to regulation by state law . . . .

The foregoing Opinion, which the court of appeals did not mention, tends to call into doubt the court's holding that §§ 1719 and 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law were intended to apply to employee benefit plans. *See Northern Group Servs., Inc. v. State Farm Mut. Auto. Ins. Co.*, No. 89-1053 (6th Cir. Mar. 21, 1990) (*also reported*, LEXIS, Genfed. Library, 1990 U.S. App. LEXIS 3979).

86.[23] But that test, developed in case law under the McCarran-Ferguson Act, had no bearing on this case. There was no need to determine whether, as a general matter, subrogation in motor vehicle accident cases was part of the insurance business. Even if it were—and there is room for disagreement about the issue[24]—

[23] The test is:

> *first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982) (emphasis in original), quoted in *Pilot Life*, 481 U.S. at 49, and *Metropolitan Life*, 471 U.S. at 743.

[24] There is a split in the circuits about whether, under this three-part test, an anti-subrogation law regulates the business of insurance. The Ninth Circuit agrees with the court below. *Pacyga*, 801 F.2d at 1161. (*Pacyga* held that Arizona's anti-subrogation law, although within the saving clause, was pre-empted by the deemer clause. *Id.* at 1161-62.)

On the other hand, the Eighth Circuit has held that a State's common law rule against subrogation was not saved from pre-emption under Section 514(b)(2)(A) in light of the fact that "subrogation does not transfer the risk from a policyholder to his or her insurer." *Baxter v. Lynn*, 886 F.2d 182, 186 (8th Cir. 1989). This appears correct. With respect to the Pennsylvania law, the provider of benefits is merely engaging in the practice of seeking reimbursement for expenses already paid on the injured party's behalf. It is not changing the risk allocation between the plan or insurer and the injured party.

In addition, the anti-subrogation law in *Baxter* and the Pennsylvania law in this case fail to satisfy part three of the test because neither the practice of subrogation nor the laws outlawing it are "limited to entities within the insurance industry." *Pireno*, 458 U.S. at 129, quoted in *Pilot Life*, 481 U.S. at 49, and *Metropolitan Life*, 471 U.S. at 743.

As discussed in the text, however, we do not believe this test has any bearing on the question presented in this case.

ERISA posed no threat to Pennsylvania's ban on the practice by insurance companies. The question here was whether application of the same restriction to employee benefit plans could escape pre-emption. Because a law barring plans from subrogating does not regulate insurance, the answer was clear—ERISA pre-empted Pennsylvania's anti-subrogation provision insofar as it applied to plans.

III. THE COURT OF APPEALS MISCONSTRUED THE DEEMER CLAUSE

Because Section 514(b)(2)(A) did not save the Pennsylvania statute insofar as it regulated employee benefit plans, that should have been the end of the matter. Having misconstrued the saving clause, however, the court of appeals found it necessary to consider the effect of Section 514(b)(2)(B), the deemer clause, which provides:

> Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

The clause is unambiguous. While the saving clause preserves the States' authority to regulate insurance even when employee benefit plans are thereby affected, the deemer clause assures that the States will not abuse this authority by defining plans covered by ERISA as insurance companies or as entities engaged in the business of insurance.[25]

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[25] For example, if Pennsylvania had barred only insurance companies from subrogating in motor vehicle accident cases, and then defined "insurance companies" to include employee benefit plans, the deemer clause would prevent the law from avoiding pre-emption insofar as it dealt with such plans.

The court of appeals, however, thought that "the deemer clause is meant mainly to reach back-door attempts by states to regulate core ERISA concerns in the guise of insurance regulation." 885 F.2d at 86. "Core ERISA concerns" were, in the court's view, "reporting, disclosure and nonforfeitability." *Id.* at 88. The consequence of the court's ruling is that the States are free to regulate all other aspects of employee benefit plans so long as they do so in a law primarily regulating insurance.

Why Congress would have intended to permit such broad State authority over employee benefit plans is difficult to understand. Still less is it apparent how the language of the deemer clause can support the court's notion that States may define employee benefit plans as insurance companies in "non-core" areas but not in areas at the "core" of ERISA. The clause itself contains no such qualifications. It provides, without exception, that such plans cannot be considered insurance companies under State laws regulating insurance.

To make matters worse, the court of appeals based its reading of the deemer clause on legislative proposals Congress expressly rejected. One of the last versions of ERISA's pre-emption provision, for example, would have specifically superseded all state laws "as they may now or hereafter relate to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies." *Id.* at 87, quoting from "2 Legislative History of the Employee Retirement Income Security Act of 1974 at 2920-22." In light of this history, the court thought that the deemer clause, as enacted, "was meant to do the more narrow, specified work which the original version of the preemption clause was meant to do." 885 F.2d at 88. In further support of its conclusion, the court relied

on the following remarks of Senator Javits, supporting the final version:

> In view of Federal preemption, State laws compelling disclosure from private welfare or pension plans . . . unless a criminal statute of general application . . . will be superseded.

120 Cong. Rec. 29,942 (1974), cited by the court below, 885 F.2d at 88.

The court is clearly mistaken. The earlier versions of ERISA's pre-emption clauses were considerably narrower than those enacted. Congress made a deliberate choice to abandon those limited proposals in favor of broad pre-emption. As the Court explained in *Shaw*, 463 U.S. at 98, the "bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's pre-emptive scope was as broad as its language."

By reading back into the deemer clause the limitations Congress rejected, the court below violated one of the cardinal principles of statutory interpretation. As the Court held in *INS v. Cardoza-Fonseca*, 480 U.S. 421, 442-43 (1987), "'[f]ew principles of statutory construction are more compelling than the proposition that Congress does not intend *sub silentio* to enact statutory language that it has earlier discarded in favor of other language.' *Nachman v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 392-93 (1980) (Stewart, J., dissenting)." Moreover, Senator Javits' remarks, quoted by the court, do not have the significance the court attributed to them. Senator Javits merely gave an example of a State law that would be pre-empted under the bill as enacted. That the same law would have been pre-empted under the earlier version is hardly surprising in light of the fact that Congress

deliberately made the final pre-emption section much broader in scope. By no means can Senator Javits' remarks support the court's conclusion that Congress intended to limit the final provision to the narrower scope of the discarded version.

The court of appeals offered another rationale for its interpretation of the deemer clause:

> Any reading other than one confined to the central aspects of ERISA would either have the deemer clause swallow the savings clause or read into the statute other distinctions that are not there.

885 F.2d at 88. Apparently the court thought that it would be senseless for the deemer clause to strike down all laws regulating both insurance companies and employee benefit plans when the saving clause rescues those laws in their entirety.

But the problem the court identified was of its own making. If the court had correctly interpreted the saving clause, the Pennsylvania statute would have been pre-empted insofar as it applied to self-funded ERISA plans. The court would then not have felt constrained to read into the deemer clause "distinctions that are not there," as it did. *Id.* The deemer clause simply prevents States from shielding their laws by deeming employee benefit plans to be insurance companies. The plain meaning of the clause, together with a proper interpretation of the saving clause, fully accomplishes Congress's objectives of immunizing self-funded plans from State regulation while preserving the States' traditional authority over the insurance industry.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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